STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	05/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 23, 24, 25, 26, 27, and 31, 2016. Facility number: 000150 Provider number: 155246 Aim number: 100267000 Census bed type: SNF/NF: 72 Total: 72 Census payor type: Medicare: 2 Medicaid: 60 Other: 10 Total: 72 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 32883 on 6/3/16.	F 0000	F 0000. This plan of correction is to serve as Chesterton Manor's credible allegation of compliance to the survey of re-licensure on May 31, 2016. Submission of this plan ofcorrection does not constitute an admission by Chesterton Manor or its management company that the allegations contained in this survey report are a true and accurate portrayal of the provisions of nursing care and other services in this facility. We are respectfully requesting a desk review for paper compliance as resolution for this survey event, and maintain the facility is in substantial compliance for the deficiencies cited as of June 30, 2016.	
F 0224	483.13(c)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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SS=D Bldg. 00	PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure each resident was free from misappropriation of property related to drug diversion for 3 of 3 residents reviewed for abuse. (Residents #5, #37, &, #101) Finding includes: The abuse allegation of misappropriation of property provided by the Director of Nursing was reviewed on 5/26/16 at 10:45 a.m. The allegation of medication diversion was dated 4/22/16. The DON reported a discrepancy of controlled substance found on 4/21/16. On 4/21/16 at 11:15 p.m., LPN #4, the night shift nurse, texted the DON and notified her when she and the second shift nurse RN #3 counted the 300 hall medication cart narcotics someone had taken 2 dose packs and punched out the Hydrocodone replacing them with a look a like and taped the back. LPN #4 indicated to the DON the last time she had worked the	F 0224	**F224 483.13 Prohibit Mistreatment/Neglect/Misappropriation:** It is the practice of Chesterton Manor to ensure residents are not subjected to misappropriation of property. 1.Resident #5, #37, & #101 has the potential to be affected by this alleged deficiency. 2.All Residents orders related to controlled substances have been reviewed and compared with controlled substances available. This was a 100% Audit to determine and identify if any other residents were affected with no other deficient practice identified. 3.All licensed nurses have been re-educated on this policy June 16, 2016. All controlled substance orders have been reviewed. In addition to the review and re-education, the DON, or her designee, is conducting a quality improvement audit to ensure all residents continue to be free of Misappropriation of Property. All Resident controlled substances will be monitored weekly for 30 days, then monthly for 6 months. Results of these audits will be reported	06/30/2016

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	cards were not tampered with which was 4/19/16. On 4/22/16 the nursing schedule was compared to the narcotic count sheet and all the nurses were interviewed. The controlled substances involved were Resident #5's routine Hydrocodone 3/325 mg was diverted and replaced with Hydroxychloroquine. Resident #101's routine Hydrocodone 7.5/325 mg was diverted and replaced with Hydroxychloroquine. Resident #37's Hydroxychoroquine was diverted from her packaged and replaced in above. The record for Resident #5 was reviewed on 5/24/16 at 2:20 p.m. The resident's diagnoses included, but were not limited to, planned post procedural wound closure, pain left wrist, spinal stenosis, abnormal posture, high blood pressure, osteoarthritis, morbid obesity, and epilepsy. The Annual 3/16/16 Minimum Data Set (MDS) assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was alert and oriented. The resident received scheduled pain medication, and occasionally had pain in the last 5 days. The resident indicated in the interview		monthly to the Quality Assurance meeting. Any negative findings will add another four weeks of audits until 100% compliance is achieved. 4.Date of Completion: June 30, 2016.	

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	her pain intensity score was 3 out of 10. The current 3/27/16 plan of care indicated the resident had chronic pain related to peripheral neuropathy, spinal stenosis, and the diagnosis of osteoarthritis. The Nursing approaches were to administer analgesia (pain medication) as prescribed. Physician's Orders on the 4/2016 summary, with an original date of 9/9/15, indicated Hydrocodone (a narcotic pain medication) 5 milligrams (mg)/325 mg 1 tab three times a day. The record for Resident #37 was reviewed on 5/24/16 at 2:08 p.m. The resident's diagnoses included, but were limited to, diabetes mellitus, auto immune hepatitis, diverticulosis, chronic pain, pubic fracture, high blood pressure, liver inflammatory disease, and osteoarthritis. The Minimum Data Set (MDS) assessment dated 3/29/16, indicated the resident had a Brief Interview for Mental Status (BIMS) of 13 indicating, she was alert and oriented. The resident received scheduled pain medication, and frequently had pain. The resident indicated in the last 10 days her pain level was a 2 out of 10.			

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The current 3/2016 plan of care indicated the resident had pain related to lower back right shoulder and leg weakness. The Nursing approaches were to provide pain medication as ordered.

Physician's Orders on the 4/2016 summary indicated the resident received Hydroxychloroquine (a medication used to treat the inflammation of rheumatoid arthritis) 200 milligrams (mg) 1 tab twice a day. The resident also received Hydrocodone 7.5-325 mg 1 tab every 6 hours.

The record for Resident #101 was reviewed on 5/25/16 at 8:43 a.m. The resident's diagnoses included, but were not limited to, hearing loss, high blood pressure, dementia with behaviors, depression, peripheral vascular disease, rheumatoid arthritis, diabetes, diabetic neuropathy, low back pain, and pain unspecified.

The Admission Minimum Data Set (MDS) assessment dated 3/15/16 indicated the resident had Brief Interview for Mental Status (BIMS) score of 3, indicating she was not alert and oriented and severely impaired for decision making. The resident was not able to be interviewed for pain, however, there were

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	no physical signs the resident was in pain. Physician's Orders on the 4/2016 summary indicated the resident received Hydrocodone 7.5 mg/325 mg 1 tab twice a day. All the interviews and investigation led to one particular nurse LPN #1, who was rehired in 7/2015. The paperwork for narcotics were reviewed and compared to clock in and out times and found to be inconsistent. LPN #1 was assigned the 300 hall med cart on 4/21 and 4/22 for the day shift. The DON, Nurse Consultant, and the Administrator conducted a second interview with LPN #1. The Nurse Consultant interviewed LPN #1 and asked her about counting narcotics before and after her shifts. She also pulled old narcotic resident sheets and found where the nurse had signed out the narcotics at times she was not actually working. LPN #1 had no response to the above allegations. LPN #1 finally admitted she took the narcotics and gave them to a family member who was having surgery on the following Wednesday of that week. LPN #1 was immediately suspended and			

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	then terminated on 4/26/16. Interview with the DON on 5/25/16 at 11:45 a.m., indicated LPN #1 admitted stealing the narcotics during the second interview with the Nurse Consultant and the Administrator. The DON indicated LPN #1 took the Hydrocodone from the two residents to give to a family member who was having surgery in the near future. The DON indicated the nurse also admitted she had taken the look alike medication of Hydroxychloroquine from another resident to replace the stolen Hydrocodone. Interview with the Nurse Consultant on 5/26/16 at 11:50 a.m., indicated she was present during LPN #1's interview and she did admit to stealing the medication for a family member. The current 8/24/15 Reportable Incidents policy provided by the DON on 5/27/16 at 9:45 a.m., indicated "Misappropriation of Resident Property was deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a Resident's property of money without the Resident's consent." 3.1-28(a)			

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure a resident's plan of care was followed related to tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing) care and suctioning for 1 of 1 resident reviewed for tracheostomy care of the 1 resident who met the criteria for tracheostomy care. (Resident #35) Finding includes: On 5/24/16 at 2:56 p.m., Resident #35 was observed in bed. The resident had a tracheostomy (trach) observed with an air humidification system attached. The resident indicated at the time he was not receiving daily trach care and the staff were not suctioning him in a timely manner. The record for Resident #35 was reviewed on 5/24/16 at 3:07 p.m. His	F 0282	**F282 483.20 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.** It is the practice of Chesterton Manor to ensure aresident's plan of care is followed related to tracheostomy care and suctioningfor residents who met the criteria for tracheostomy care. I. One Resident, Resident # 35, has a tracheostomy,daily tracheostomy care was being completed but not being documented on in the treatment administration record. II. One Residents who has a tracheostomy has the potential to be affected by this alleged deficiency. III. As noted in the survey findings, Chesterton Manor has a Tracheostomy Care Policy. A clarification order for Resident #35 has been received. All plans of care for Resident #35 have been reviewed for compliance. No other deficient practice identified. Licensed	06/30/2016

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	diagnoses included, but were not limited to, quadriplegia, hand contractures, trach, and chronic respiratory failure. The Significant Change Minimum Data Set (MDS) assessment dated 4/5/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was alert and oriented. The resident was an extensive assist with a physical assist of two people for transfers and had upper and lower extremity impairments on both sides. The special treatments included, but were not limited to, trach care and suctioning. The current and updated care plan indicated, the resident had a tracheostomy related to an injury. The interventions included, but were not limited to, suction and trach care every shift as ordered and prn (as needed). Review of the 5/2016 Physician's Orders indicated, may suction as needed for increased secretions. There were no orders related to trach care. Review of the 5/2016 Treatment Administration Record (TAR) indicated no documention related to trach care. On 5/25/16 at 8:56 a.m., staff interview		nurses have been re-educated on the aforementioned policy emphasizing the nursing team will record tracheostomy care in the treatment administration record on June 13, 2016. IV. All Residents orders related to tracheostomy care have been reviewed. In addition to the review and re-education noted above, the DON, or her designee, is conducting a quality improvement audit to ensure all residents care plans are reviewed with each comprehensive assessmentand followed as well as review of each care plan related to tracheostomy care and suctioning for residents who met the criteria for tracheostomy care. All residents receiving tracheostomy care and all resident care plans with each comprehensive assessment will be monitored weekly for 30 days, then monthly for 6 months. Results of these audits will be reported monthly to the Quality Assurance meeting. Any negative findings will add another four weeks of audits until 100% compliance is achieved. V. Date of Completion: June 30, 2016.	

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	with LPN #5 indicated, on her scheduled days she provided care for the resident, which included as needed suctioning. She further indicated, "I think the night shift provides daily trach care." On 5/25/16 at 2:16 p.m., staff interview with the Director of Nursing (DON) indicated the staff do not document on the TAR when trach care is completed, "It's our facility policy and is done daily." Continued interview indicated she had no documentation indicating trach care was provided daily and, moving forward, indicated the nursing staff will be signing out trach care on the TAR. Review of the current Tracheostomy Care policy on 5/25/16 at 1:44 p.m., indicated "Tracheostomy Care performed daily to maintain an airway, maintain cleanliness of the tracheostomy wound, and prevent infections." 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and			

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	services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, record review, and interview, the facility failed to ensure non-pressure areas related to bruises were assessed, documented and monitored for 1 of 3 residents reviewed for non-pressure related skin conditions of the 4 residents who met the criteria for non-pressure related skin conditions. (Resident #96) Finding includes: On 5/23/16 at 10:22 a.m., Resident #96 was observed with red/purple discolorations noted to her right hand and her left hand ring finger. On 5/26/16 at 1:34 p.m., the Assistant Director of Nursing (ADON) was observed performing a skin assessment for the resident. At that time, she indicated the resident had three bruises. She assessed and measured each one as followed: Left 4th finger bruise 1 centimeter (cm) by 1 cm. The top of the right hand 1 cm by 0.5 cm and the right thumb 0.4 cm by 0.5 cm. The record for Resident #96 was reviewed on 5/26/16 at 10:00 a.m. The	F 0309	**F309 483.25 Qualityof Care** **Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. It is the practice of Chesterton Manor to ensurenon-pressure related skin conditions are assessed, documented and monitored.** 1.One Resident, Resident # 96, was observed 5/23/16 with red/purple discolorations noted to her right hand and her left hand ringfinger without supportive documentation until 5/26/16. 2.All Residents have the potential to be affectedby this alleged deficiency. All residents assessed without findings. No other residents were effected. 3.As noted in the survey findings, Chesterton Manor has an Accidents and Incidents-Assessing, Investigating, and Reportingpolicy. Licensed nurses have been re-educated on the afore mentioned policy on June13, 2016. 4.All Residents related to non-pressure skin conditions have been reviewed. In addition	06/30/2016

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	resident's diagnoses included, but were not limited to, altered mental status, pacemaker, cancer, dementia, high blood pressure, congestive heart failure, and a history of falls. The Quarterly Minimum Data Set (MDS) assessment dated 3/2/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 6 which indicated she was not alert and oriented. The resident had no behaviors, or mood problems. She was an extensive assist with one person physical assist for transfers, bed mobility, dressing and toilet use. The current 5/13/16 plan of care indicated the resident had potential problems for complications for injury related to Aspirin therapy. The Nursing approaches were to monitor/document/report to the nurse bruising. Observe skin with each encounter for new bruising or skin tears. The last non-pressure wound sheet dated 4/1/16 indicated the resident had bruises on the left anticubital space dark purple discoloration, left back of hand dark purple discoloration, and the right forearm light purple discoloration. There were no other non-pressure wound sheets.		to the review and re-education noted above, theDON, or her designee, is conducting a quality improvement audit to ensurenon-pressure areas are assessed, documented and monitored. All residents willbe included in the audit related to non-pressure skin conditions, in addition to the weekly skin assessments, and be monitored weekly for 30 days, then monthly for 6 months. Results of these audits will be reported monthly to the Quality Assurance meeting. Any negative findings will add another four weeks of audits until 100% compliance is achieved. 5.Date of Completion: June 30, 2016.	

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Nursing progress Notes dated 5/22-5/26 indicated there was no documentation of any bruising to her hands or fingers.

The last shower skin assessment sheet dated 5/23/16 indicated the resident had no alterations in skin integrity.

Physician's Orders on the current 5/2016 summary indicated the resident received Aspirin 81 milligrams (mg) daily.

Interview with the ADON on 5/26/16 at 1:34 p.m., indicated a new system had just been implemented to monitor and assess bruises. She indicated an incident report was to be completed and the areas were to be measured and documented on the non-pressure sheets.

Interview with RN #1 on 5/26/16 at 2:00 p.m., indicated she was unaware of the bruises on the resident's hand and finger. She further indicated no information was passed on to her from the midnight shift during end of shift report regarding the bruises.

The current 4/2011 Accidents and Incidents-Assessing, Investigating, and Reporting policy provided by the Assistant Director of Nursing on 5/26/16 at 2:40 p.m., indicated the licensed nurse

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	will complete an assessment of the resident involved in any incident. Documentation of that assessment may include redness, swelling, bruising, range of motion, pain, bleeding, and change in condition. 3.1-37(a)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure the resident's side rails were secure while in the upright position for 1 bed observed with side rails. (Room 401-A) Finding includes: 1. On 5/24/16 at 9:23 a.m., 2:40 p.m., and 3:45 p.m., the left side rail in room 401-A was observed in the upright position. At those times, the side rail was loose and wobbled back and forth. 2. On 5/25/16 at 9:23 a.m., and 12:57	F 0323	**F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICESThe facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Finding includes: 1. The left side rail identified in room 401-A has been repaired and restored to normal functionality, a 100 % audit has been completed to determine if any other resident side rails are**	06/30/2016

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	p.m., the left side rail in room 401-A was observed in the upright position. At those times, the side rail was loose and wobbled back and forth. Interview with the Maintenance Supervisor on 5/25/16 at 1:10 p.m., indicated he was unaware the rail was loose. He further indicated it was a safety hazard and needed to be fixed. 3.1-45(a)(1)		**loose or wobbly or in need of repairs. All side rail determined to be affected have been and restored to normal functionality. a) An audit tool has been created in the TELs electronic work order system for weekly audits by maintenance as a task for weekly rounding and auditing. This will be completed weekly as a task for100 % audits of bed rails. In addition to weekly rounds, a random audit of three resident bed rails will be conducted weekly x 6 months. If the deficient practice is discovered and addition month will be added to task and a record will be kept in the TELs work order system. Results of TELs audits will be printed off weekly and kept in the POC binder as well as reporting the finding in Monthly QA meetings. Staff has been in service on side rails and resident safety and reporting side rail issues in the TELs electronic work order system with a completion date of 6/17/2016.**	
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate			

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	155246	A. BUILDING 00 B. WING	05/31/2016

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	monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure each resident's medication regime was free from unnecessary medications related to adequate dose of Insulin (a medication for high blood sugar) for 2 of 5 residents reviewed for unnecessary medications. The facility also failed to obtain a PT/INR (a blood test that measures how long it takes blood to clot) for 1 of 5 residents reviewed for unnecessary medications. (Residents #33 and #16) Findings include: 1. The record for Resident #33 was reviewed on 5/26/16 at 9:51 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's, diabetes, and dementia with behaviors.	F 0329	**F329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS It is the practice of Chesterton Manor to ensure that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is defined as any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications of use; or in the presence of adverse consequences which indicate the dose shouldbe reduced or discontinued; or any combination of these reasons** I. Resident (# 16) related to adequate doses of sliding scale Insulin and another Resident (# 33) related to	06/30/2016

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	The Physician's Order dated 11/21/14 indicated an order for sliding scale (insulin given per blood glucose test result) Novolog (insulin) subcutaneous (under the skin) before meals, with the following doses: 70-100=3 units 101-150=5 units 151-200=9 units 201-250=13 units 251-300=17 units 301-350=21 units Continued review of the Physician's Orders indicated a new order dated 5/25/16 for sliding scale Novolog subcutaneous before meals, with the following doses: <70=0 units 70-100=3 units 101-150=5 units 151-200=10 units 201-250=15 units 251-300=20 units 301-350=25 units >351=Notify Physician The 2/2016 Medication Administration Record (MAR) indicated, on 2/23/16 the resident's blood glucose test result before breakfast was 161, 5 units of insulin was given, 9 units of insulin should have been administered.		adequate doses of sliding scale Insulin and obtaining a PT/INR lab draw. Resident (#16) & (#33) lab orders clarified with physician and completed per physician order. DON, or her designee, will conduct an additional check to assure all labs are processed appropriately. II. All residents who have orders for sliding scale insulin and PT/INR lab draws have the potential to be affected by this alleged deficiency. All Resident lab orders reviewed and completed as ordered. Resident(#16) & (#33) lab orders clarified with physician and completed per physician order. DON, or her designee,will conduct an additional check to assure all labs are processed appropriately. III. As noted in the survey findings, Chesterton Manor has a Diabetes Mellitus Policy and a Lab Ordering and Reporting Policy inplace. Licensed nurses have been re-educated on the aforementioned policies on June 16, 2016. IV. All sliding scale insulin orders and all PT/INR labs for all Residents have been reviewed. In addition to the review and re-education noted above, the DON, or her designee, is conducting a quality improvement audit to ensure residents medication regimen is free from unnecessary medications related to adequate doses of sliding scale Insulin and obtaining PT/INR results. A sample of 5 residents	

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	The 3/20/16 MAR indicated, on 3/3/16 the resident's blood glucose test result before lunch was 226, 17 units of insulin was given, 13 units of insulin should have been administered. On 3/27/16 the resident's blood glucose test result before lunch was 191, 13 units of insulin was given, 9 units of insulin should have been administered. And on 3/27/16 the resident's blood glucose test result before dinner was 179, 5 units of insulin was given, 9 units of insulin should have been administered. The 4/2016 MAR indicated, on 4/27/16 the resident's blood glucose test result before dinner was 103, 3 units of insulin was given, 5 units of insulin should have been administered. The 5/2016 MAR indicated, on 5/8/16 the resident's blood glucose test result before breakfast was 93, 5 units of insulin was given, 3 units of insulin should have been administered. On 5/26/16 the resident's blood glucose test result before breakfast was 168, 9 units of insulin was given, 10 units of insulin should have been administered. On 5/27/16 at 10:58 a.m., interview with the Director of Nursing indicated the nursing staff administered the incorrect		receiving sliding scale insulin will be monitored for accuracy 3 times per week for 30 days, then monthly for 6 months. All residents receiving lab draws and results will be monitored weekly for 30 days, then monthly for 6months. Results of these audits will be reported monthly to the Quality Assurance meeting. Any negative findings will add another four weeks of audits until 100% compliance is achieved.V. Date of Completion: June 30, 2016.	

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	dose of insulin on the above dates. 2. The clinical record for Resident #16 was reviewed on 5/25/16 at 2:35 p.m. The resident's diagnoses included, but not limited to, diabetes mellitus, and a history of pulmonary emboli. The 30-day Minimum Data Set (MDS) assessment dated 4/15/16 indicated the resident was moderately impaired with a Brief Interview for Mental Status (BIMS) score of 8. The resident received an anticoagulant medication and insulin daily during the observation period. a. The resident's care plan dated 3/6/16 indicated the resident was on an anticoagulant therapy related to disease. The interventions included, but were not limited to, daily skin inspection and or during showers, labs as ordered, and report abnormal lab results to the Physician. The 5/2016 Physician's Order Summary (POS) was reviewed. An order dated 3/18/16 indicated Warfarin Sodium (anticoagulant medication - helps thin the blood) 4 milligrams (mg) daily. A Physician's Order dated 4/23/16 indicated to continue the 4 mg of Warfarin and recheck the PT/INR again on 4/29/16.			

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	An order dated 4/29/16 indicated to continue with the same dose and recheck the PT/INR on 5/10/16. Review of the laboratory results indicated the following: -INR on 4/22/16=1.7 -INR on 4/29/16=1.9 -There was no result for the PT/INR ordered on 5/10/16. Nursing Notes were reviewed from 4/22/16 to 5/12/16. On 4/29/16 the notes indicated "PT/INR sent to MD (Medical Doctor) with no Warfarin change at this time. Lab order received for PT/INR to do May 10. Order noted et faxed. Appropriate parties notified." Interview with LPN #2 on 5/26/16 at 2:47 p.m., indicated the resident had not received the lab draw, however, there was documentation sent to the lab. She further indicated the staff had not followed up with the lab order or notified the resident's Physician that the lab had not been drawn for the resident. The Physician was notified by RN #2 on 5/27/16 at 11:40 a.m. that the lab was never drawn. The physician ordered a stat (immediately) PT/INR lab draw.			

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	Interview with RN #2 on 5/27/16 at 1:50 p.m., indicated the lab that had been previously ordered was drawn and the results for the INR were 1.9 with Physician Orders to maintain the same daily dose of warfarin. A current facility policy provided by the Director of Nursing (DON) on 5/31/16 at 10:26 a.m., titled, "Lab Ordering and Reporting Procedure" from IDE Management dated 4/2013, indicated, "...POLICY: It is the policy of this facility to order labs and report results in a timely manner...." b. The resident's care plan dated 4/23/16 indicated the resident was at risk for complications associated with diabetes mellitus. The interventions included, but were not limited to, glucose monitoring, and diabetes medication as prescribed. Physician's order dated 1/15/16, indicated the resident was to receive Novolog insulin by the way of a flexpen subcutaneously (sq) four times a day based on a sliding scale at 7:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m. The sliding scale dose was as follows: 0-130=0 units 131-170=2 units			

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	171-210=3 units 211-250=5 units 251-290=6 units 291-330=7 units Above 330=8 units and call the Physician The May 2016 Medication Administration Record (MAR), indicated the following: 5/15/16 at 9:00 p.m. the resident's blood sugar was 310, documentation indicated the resident received 8 units of insulin. The resident should have received 7 units of insulin at that time. 5/24/16 at 9 :00 p.m. the resident's blood sugar was 328, documentation indicated the resident received 8 units of insulin. The resident should have received 7 units of insulin at that time. 5/26/16 at 6:00 a.m. the resident's blood sugar was 139, documentation indicated the resident received 3 units of insulin. The resident should have received 2 units of insulin at that time. Interview with the Regional Director of Clinical Services on 5/27/16 at 11:45 a.m., indicated the resident's sliding scale insulin was given incorrectly on the above dates.			

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	A current facility policy provided by the Director of Nursing (DON) on 5/31/16 at 10:30 a.m., titled, "Diabetes Mellitus - Routine Care", indicated, "...Purpose: To provide nursing staff with guidelines for implementing care for the resident with diabetes mellitus. Objective: To provide care that will enable the resident to achieve and or maintain control of diabetes and to function safely in a natural environment..." 3.1-48(a)(6) 3.1-49(a)			
F 0371 SS=D Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food was stored, prepared and served under sanitary conditions related to the use of gloves, dirty and greasy ovens, griddles, storage room, and cabinets for 1 of 1 kitchens. There was expired juice in the Unit Pantry for 1 of 1 pantries. (The	F 0371	**DeficiencyID: F371** 1. a. Dietary cook was inserviced by the Dietary Manager, one-on-one on 5/23/2016 on glove usage during food prep. Cook was also given a copy of the handwashing policy. All Dietary staff will be in-serviced on the use of glove during food prep and hand washing on 6/21/16 Dietary Manager	06/30/2016

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	Main Kitchen and the Unit Pantry) Findings include: 1. On 5/23/16 at 8:50 a.m. the following was observed during the Brief Kitchen Sanitation tour with the Dietary Food Manager (DFM): a. Dietary Cook #1 was observed with gloves to both of her hands. At that time, she was using a pair of scissors to cut open packages of raw spare ribs. She was also observed touching the packages of meat with her gloved hands. The Cook was observed to remove the ribs from the packages with her gloved hands and placed them in a pan for cooking. She was not observed to change her gloves in between using the scissors and touching the packages of meat. The current and undated Handwashing and Glove use policy provided by the Nurse Consultant on 5/31/16 at 11:00 a.m., indicated gloves should be used when handling food, if tongs or utensils will not do the job. Gloves should only be used once and then discarded. Important to remember that gloves can give a false sense of security and can carry germs as hands. 2. On 5/26/16 at 9:10 a.m., the following		ordesignee will conduct random observations of staff during meal prep to ensure compliance with the above policies. See attached form. 2. a. Convection oven was thoroughly cleaned and all dust and grease was removed on 5/24/16. b. The corners and edges of the griddle were thoroughly cleaned on 6/9/16 c. The traditional oven was thoroughly cleaned on 5/23/16. d. Floor in the dry food storage room was swept and wet mopped on 5/23/16. e. All food transportation carts were thoroughly cleaned with a pressure washer and disinfected. This included 100 % of small and large service carts, all Trash cans and associated dollies, four wheel plate carts, mixer stand, multi purpose drink carts and movable storage racks. This was completed on 6/17/16. f. The four white cabinets were cleaned and sanitized on 6/9/16 and have been repaired and repainted Dietary Manager or designee will conduct a weekly sanitation audit to ensure sanitary conditions in the kitchen. See attached form. 3. The expired products were disposed of on 5/31/16. The Dietary staff will monitor the contents of each refrigerator to ensure that there are no expired products, three time per week. See attached form. Dietary Manager or designee will conduct a weekly sanitation audit 3x per	

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	was observed during the Full Kitchen Sanitation tour with the DFM: a. All the sides of the convection oven were dirty and greasy. The inside of the oven doors were dirty and brown stained. The knobs on the outside of the oven were sticky and dirty to touch. There was dust around and in the corners of the front panel. b. There was a large amount of thick black sludge and grease noted around the corner edges on top of the griddle. c. The inside of the traditional ovens were dirty with food spillage. d. The floor in the dry food storage room was dirty. There were sugar packets, fortune cookies, food crumbs, and a package of vanilla wafers observed on the floor. e. There were 3 transportation carts that were sticky to touch. The carts were used to transport food. f. There were 4 white cabinets above the counter, which stored dishes, that were dirty and sticky to touch. Interview with the DFM, at that time, indicated all the above was in need of		week for 90 days, then one per week for 90 days, should the deficient practice be identified, audits will resume 3x weekly for 4 weeks until deficiency is corrected. Results of these reviews will be presented monthly at QA meeting, times 90 days. If after 90 days or review, no trends or patterns are identified (three deficient practices per month is considered a trend) then results will be reviewed quarterly. Compliance date: 6/30/16	

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	cleaning. 3. On 5/31/16 at 8:55 a.m., the pantry on the Main Nursing unit was observed. Inside the refrigerator there were 2 unopened GNC Total Lean Shakes with a "Best Buy" date of 8/26/15. There was 1 opened container of Thirster Thickened Orange Juice with a "Best Buy" date of March 25, 2016. The current and undated Refrigerated Leftover Storage policy provided by the DFM on 5/31/16 at 10:45 a.m., indicated the product will be disposed of on or before the product expiration date. Interview with the DFM on 5/31/16 at 9:09 a.m., indicated the items were expired and should have been thrown away. 3.1-21(i)(3)			
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate			

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	reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were labeled and stored properly related to dating medications when opened, labeling over the counter medications, and not using inhalers past the expiration date for 2 of 4 Medication carts in the facility. (Unit 1 and Unit 3) Findings include:	F 0431	**F431 483.60 (e) Storage of Drugs and Biologicals It is the practice of Chesterton Manor to ensure medications are labeled and stored properly related to dating medications when opened, labeling over the counter medications, and not using inhalers past the expiration date.** 1.Medication Cart on Unit 1 and Medication Cart on Unit 3 presented as outlined in the	06/30/2016

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	1. Observation of the Medication Cart on Unit 3 on 5/24/16 at 2:28 p.m., indicated the following: a. An Atrovent inhaler (an inhaler used to treat asthma) was dated as being opened 12/12/15. b. A bottle of over the counter Aspirin was not labeled with a resident's name and/or the Physician's name. c. A Combivent inhaler (an inhaler used to treat respiratory issues) was dated as being opened 2/1/16. Interview with LPN #3 at the time, indicated the bottle of Aspirin should have been labeled with the resident's name as well as the Physician's name. She also indicated the inhalers were usually good for 90-days after being opened. 2. Observation of the Medication Cart on Unit 1 on 5/24/16 at 2:45 p.m., indicated a Combivent inhaler was not dated when opened. Interview with LPN #3 at the time, indicated the inhaler should have been dated when opened. The Medication labeling policy was		survey findings. Medications in Medication Cart on Unit 1 and Medication Cart on Unit 3 on were labeled appropriately with no expirationdates. All Medication Carts on Units 1,2, 3 & 4 were labeled appropriately with no expiration dates. 2.All residents who have prescribed medications have the potential to be affected by this alleged deficiency. 3.As noted in the survey findings, Chesterton Manor has a Miscellaneous Product Expiration Date Policy and a Medication Labeling Policy in place. Licensed nurses have been re-educated on the afore mentioned policies on June 16, 2016. 4.All current medications have been reviewed. In addition to the review and re-education noted above the DON, or her designee, is conducting a quality improvement audit to ensure medications are labeled and stored properly related to the dating of medications when opened, labeling over the counter medications, and inhalers are not present past the expiration date. All Medication carts will be audited for medications dated when opened, labeling of over the counter medication appropriate and inhalers are not presentpast expiration dates 3 times per week for 30 days, then monthly for 6 months. Results of these audits will be reported monthly to the	

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	155246	A. BUILDING 00 B. WING	05/31/2016

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	reviewed on 5/31/16 at 11:11 a.m. The policy was provided by the Nurse Consultant and identified as current. The policy indicated the following: Non-prescription medications not labeled by the Pharmacy are kept in the manufacturer's original container and identified with the resident's name. Facility personnel may write the resident's name on the container or label as long as the required information is not covered. The Miscellaneous Product Expiration Date policy was reviewed on 5/31/16 at 11:20 a.m. The policy was provided by the Nurse Consultant and identified as current. The policy indicated Combivent expired three months after first actuation. The Nurse Consultant also indicated this was the same for Atrovent. 3.1-25(j) 3.1-25(o)		Quality Assurance meeting. Any negative findings will add another four weeks of audits until 100% compliance is achieved. 5.Date of Completion: June 30, 2016.	

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F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls and doors, marred closet doors and furniture as well as stained floor tile for 4 of 4 units throughout the facility. The facility also failed to maintain a functional and sanitary environment in the main kitchen related to dirty and rusty ceiling vents, dirty pipes, ice build up in the freezer, an accumulation of dust and debris behind the appliances, and an accumulation of dust and debris on the wheels of the transportation carts in 1 of 1 kitchen areas. (Units 1, 2, 3, and 4 and the Main Kitchen) Findings include: 1. During the Environmental Tour on 5/31/16 at 9:25 a.m., with the Maintenance and Housekeeping Supervisors, the following was observed: Unit 1 a. The black non-skid strips on the floor next to Bed "B" in Room 103 were	F 0465	F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Marred walls, marred doors, urine odors, stained floor tile and cracked base boards on 4 of 4 halls throughout the facility. In general areas of deficiency were identified as beginning presenton the following resident halls: Halls 100, 200, 300 and 400. Resident rooms were identified as specific to.., 1.) The100 hall. a. The black non-skid strips on the floornext to Bed "B" in Room 103 were peeling. The inside of the bathroomdoor was also scratched and marred. One resident resided in this room.*Maintenance has replaced Black peeling non-skid strips nest to bed “B”, the bathroom door has been repainted. b. The base of the closet door in Room 104 was scratched and marred. One resident resided in this room. *Maintenance has repainted door. c. In Room 105, the bathroom floor tile was stained underneath the sink. The bathroom door was marred on the outside. The base of the closet doors were also	06/30/2016

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	peeling. The inside of the bathroom door was also scratched and marred. One resident resided in this room. b. The base of the closet door in Room 104 was scratched and marred. One resident resided in this room. c. In Room 105, the bathroom floor tile was stained underneath the sink. The bathroom door was marred on the outside. The base of the closet doors were also marred. Two residents resided in this room. d. The dresser in Room 107 was scratched and marred. One resident resided in this room. e. The right side of the closet door was dented and marred at the base in Room 108. One resident resided in this room. f. The dresser in Room 112 was scratched and marred. A section of the wall next to the dresser and the wall by the air conditioning unit had chipped paint. The bathroom door and door frame had chipped paint. The bathroom walls were marred and the paint was chipped. The base of the closet door was scratched and marred. One resident resided in this room.		marred. Two residents resided in this room. *House Keeping has cleaned stained tile. d. The dresser in Room 107 was scratched and marred. One resident resided in this room. *Maintenance has re-stained scratches and sealed area. e. The right side of the closet door was dented and marred at the base in Room 108. One resident resided in this room. *Dent was repaired and repainted by maintenance. f. The dresser in Room 112 was scratched and marred. *Maintenance has re-stained scratches and sealed area. A section of the wall next to the dresser and thewall by the air conditioning unit had chipped paint. * Wall area where chips were present has been repainted by maintenance. The bathroom door and door frame had chipped paint. Door area and frame where chips were present has been repainted by maintenance. The bathroom walls were marred and the paint was chipped. *Maintenance has re-painted walls. The base of the closet door was scratched and marred. * The closet door has been re-painted. One resident resided in this room. 2.) The 200 hall. a.) The base of the closet door in Room 202 was marred. * The closet door has been re-painted. Two residents resided in this room.b.) The base of the closet door was scratched and marred in Room 212. * The closet door has been	

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	2. Unit 2 a. The base of the closet door in Room 202 was marred. Two residents resided in this room. b. The base of the closet door was scratched and marred in Room 212. The edge of the wall located next to the closet doors was marred and had chipped paint. Two residents resided in this room. 3. Unit 3 a. In Room 305, the base of the bathroom door was marred and had chipped paint. The floor tile in the bathroom was discolored in front of the sink and behind the toilet. The bolts at the base of the toilet were exposed. Two residents resided in this room. b. In Room 309, the closet door was scuffed and marred. The edge of the wall next to the closet door had chipped paint. The door to the room as well as the bathroom door was marred and had chipped paint. Two residents resided in this room. c. The bedside stand in Room 312 next to Bed "A" was scratched and marred. The bathroom door were scratched and marred. The bolts at the base of the toilet		re-painted. The edge of the wall located next to the closet doors was marred and had chipped paint. * Wall area where marring was present has been repainted by maintenance. Two residents resided in this room. 3.) The 300 hall. a.) In Room 305, the base of the bathroom door was marred and had chipped paint. * Wall area where chips were present has been repainted by maintenance. The floor tile in the bathroom was discolored infront of the sink and behind the toilet. * Housekeeping has removed stains from floor. The bolts at the base of the toilet were exposed. *Bolt Caps have been replaced with a new set. Two residents reside in this room. b.) In Room 309, the closet door was scuffed and marred. * The closet door has been re-painted. The edge of the wall next to the closet door had chipped paint. * The wall area with chipped paint has been re-painted. The door to the room as well as the bathroom door was marred and had chipped paint. * The doors to the room and the bathroom has been re-painted. Two residents resided in this room. c.) The bedside stand in Room 312 next to Bed "A" was scratched and marred. *The bedside stand scratches have been painted. The bathroom door were scratched and marred. * The scratched on the door to the bathroom has been re-painted. The bolts at the base of the toilet	

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	were exposed. Two residents resided in this room. 4. Unit 4 a. The bedside stand in Room 404 across from Bed "A" was scratched and marred at the base. The base of the closet doors were scratched and marred. The upper edge of the bathroom door had chipped paint. The bolts at the base of the toilet were exposed. Two residents resided in this room. b. In Room 407, the door frame and the bathroom door frame were marred and had chipped paint. The inside of the door was also marred and had chipped paint. Two residents resided in this room. c. In Room 409, the bathroom door frame was marred and chipped. The closet door was also marred. One resident resided in this room. d. The bathroom door in Room 411 did not shut correctly. The door would not latch when closed. Two residents resided in this room. e. In Room 413, the inside of the bathroom door was marred and had chipped paint. Both closet doors had black scuff marks. The baseboard by the		were exposed. *Bolt Caps have been replaced with a new set. Two residents reside in this room.4.) The 400 hall a.) The bedside stand in Room 404 across from Bed "A" was scratched and marred at the base. *The bedside stand scratches have been painted. The base of the closet doors were scratched and marred.* The closet door has been re-painted. The upper edge of the bathroom door had chipped paint. * The scratches on the upper edge of the door to the bathroom has been re-painted. The bolts at the base of the toilet were exposed. * Bolt Caps have been replaced with a new set. Two residents reside in this room. b.) In Room 407, the door frame and the bathroom door frame were marred and had chipped paint. * The scratches to the door tothe bathroom and frame have been re-painted. The inside of the door was also marred and had chipped paint. * This area has been repainted. Two residents reside inthis room. c.) In Room 409, the bathroom door frame was marred and chipped. The closet door was also marred. * The scratches to the closet door have been re-painted. One resident resided in this room. d.) The bathroom door in Room 411 did not shut correctly. The door would not latch when closed. *The door has been rehung and the frame realigned to correctly shut the	

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	bathroom door was peeling away from the wall and the wall was gouged by the bathroom door along the corner edge. Two residents resided in this room. Interview with the Maintenance Supervisor at the time, indicated all of the above areas were in need of repair. 5. On 5/23/16 at 8:50 a.m. the following was observed during the Brief Kitchen Sanitation tour with the Dietary Food Manager (DFM): a. The vent above the dish machine had a large accumulation of dirty and dust. The vent was also rusty. b. The white PVC pipes under the garbage disposal and under the three compartment sink were dirty with food and/or beverage spillage. c. There was a large amount of ice build-up on the ceiling and the floor in the walk in freezer. There were chunks of ice adhered to the floor and the ceiling was dripping with water. d. The hand washing sink by the convection oven was stained and discolored.		latch has been repaired. Two residents reside in this room. e.) In Room 413, the inside of the bathroom door was marred and had chipped paint. * This area has been repainted. Both closet doors had black scuff marks. The scuffs have been repainted. The baseboard by the bathroom door was peeling away from the wall and the wall was gouged by the bathroom door along the corner edge. *The gouged area has been repaired and repainted. The baseboard has been re-glued to the wall. Two residents resided in this room. Interview with the Maintenance Supervisor during survey indicated all the above was in need of cleaning and/or repair. Housekeeping has completed the necessary deep cleaning of rooms affected for correction of any additional stains. Maintenance will recording purposes for rooms identified by upcoming audits via the TELS work order or system. Weekly room audits via TELS system has set this as a weekly task for scuffs scrapes and side rails. An audit tool will be kept of weekly room audits. 3 times per week for 30 days,then monthly for 6 months. Results of these audits will be reported monthly tothe Quality Assurance meeting. Any negative findings will add another four weeks of audits until 100% complianceis achieved. A record of maintenance for room repairs will be kept for this period of all	

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	e. There was a large amount of dust and dirt behind the stove, convection ovens, the griddle, and the deep fryer. The gas pipes behind the stove were greasy and dusty. f. The wheels on the mixer were dirty and greasy. 6. On 5/26/16 at 9:10 a.m., the following was observed during the Full Kitchen Sanitation tour with the DFM: a. The 3 transportation carts were sticking to touch and the wheels were dirty and greasy. b. The enclosed transportation cart wheels were dirty and greasy. Interview with the DFM, at that time, indicated all the above was in need of cleaning and/or repair. 3.1-19(f)		work completed in the plan of correction book, as well as in the TELS work ordersystem and a corresponding record of the work will be placed in the system as awork order for recording purposes. This record will be completed by maintenance, the administrator, or a designee. Date of Completion for identified deficiencies: June 30, 2016.5. On 5/23/16 at 8:50 a.m. the following was observed during the Brief Kitchen Sanitation tour with the Dietary Food Manager(DFM): a. The vent above the dish machine had alarge accumulation of dirty and dust. The vent was also rusty. *The Vent has been cleaned and repainted and reinstalled. 5/23/2016 b. The white PVC pipes under the garbage disposal and under the three compartment sink were dirty with food and/or beverage spillage. * The PVC pipes under the garbage disposal were cleaned, surfaces in surrounding area was cleaned anddisinfected completed 5/23/16. c. Therewas a large amount of ice build-up on the ceiling and the floor in the walk infreezer. There were chunks of ice adhered to the floor and the ceiling was dripping with water. *The vendor was contacted to inspect the walk in freezer;they repaired and re-sealed penetration to walls and ceilings in affected areas replacement Dietary staff are monitoring, cleaning and	

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			defrosting two times/week. Completed repairs. 6/6/2016 This area will be monitored weekly and cleaned to prevent the potential for ice build-up. d. The hand washing sink by the convection oven was stained and discolored. * A thoroughcleaning of the sink and surrounding area has been completed. 5/23/2016 e. Therewas a large amount of dust and dirt behind the stove, convection ovens, the griddle,and the deep fryer. The gas pipes behind the stove were greasy anddusty. * The entire area behind the stove, grill and gas piping was degreasedand deep cleaned. Completed 5/23/2016. f. The wheelson the mixer were dirty and greasy. * Wheels on mixer werethoroughly cleaned on 6/9/16.6. On 5/26/16 at 9:10 a.m., the following was observed during the Full Kitchen Sanitation tour with the DFM: a. The 3 transportation carts were sticking to touch and the wheels were dirty and greasy. *Wheels on the transportation carts were power washed and cleaned. Completed 6/17/2016b. The enclosed transportation cart wheels were dirty and greasy. *Wheels on the enclosed transportation cart were power washed and cleaned. Completed 6/17/2016 Dietary Manager or designee will conduct a weekly sanitation audit 3x per week for 90 days,then one per week for 90 days, should the deficient practice be identified	

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			audits will resume 3x weekly for 4 weeks until deficiency is corrected. Results of these reviews will be presented monthly at QA meeting, times 90 days. If after 90 days or review, no trends or patterns are identified (three deficientpractices per month is considered a trend) then results will be reviewed quarterly.	